MDR: M4-02-4279-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $8,525.81 for date of service, 07/17/01.

   b. The request was received on 07/09/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. UB-92 HCFA(s)
   c. Medical Records
   d. EOBs
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The Commission requested two copies of additional documentation via a Fee Letter (MR116) that was mailed to the Requestor on 07/18/02. The Requestor did not respond per Rule 133.307 (g) (3). Therefore, the Commission could not forward any additional documentation to the Respondent per Rule 133.307 (g) (4). There is an initial response in the dispute packet under Exhibit II.

III. PARTIES' POSITIONS

1. Requestor: Per the Table of Disputed Services:

   "Carrier denied per code 'M' and did not supply documentation of 'methodology' per 133.304 or pay at a 'fair and reasonable' rate. In addition, based upon Carrier's previously submitted documentation for other claims, the 'wage' index rate is inappropriately applied for Pasadena, Texas which is not contingent to Houston, Texas. Carrier has also not utilized methodology consistently as required by 133.304."

2. Respondent: No position statement found in case file.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/17/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $8,525.81 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $766.47 for services rendered on the date of service in dispute above.

5. The Carrier's EOBs denied any additional reimbursement as" G – UNBUNDLING" and M – NO MAR".

6. The amount in dispute is $7,759.34 for services rendered on the date of service in dispute above.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes… HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate."

The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence in regards to fair and reasonable. The provider has not submitted additional reimbursement data for the charges billed for similar services. The requestor, per rule 133.307(g)(3)(d), must provide documentation "…if the dispute involves health care for which the commission has not established a maximum allowable reimbursement that discusses, demonstrates and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines);" The carrier, according to their denial on the EOB, asserts that they have paid a fair and reasonable reimbursement, but have not submitted a methodology to support their reimbursement. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. However, the provider has the responsibility to support their charges are fair and reasonable as the requestor. In this case, the Requestor has not provided documentation to support their position that the amount billed is fair and reasonable as required by Rule 133.307(g)(3)(d). Therefore, additional reimbursement **is not** recommended.

The above Findings and Decision are hereby issued this 17th day of March 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb